

responsible using the results of any examination performed in the overall management of the beneficiary's specific medical problem.

(b) *Condition for coverage of screening fecal-occult blood tests.* Medicare Part B pays for a screening fecal-occult blood test if it is ordered in writing by the beneficiary's attending physician.

(c) *Limitations on coverage of screening fecal-occult blood tests.* (1) Payment may not be made for a screening fecal-occult blood test performed for an individual under age 50.

(2) For an individual 50 years of age or over, payment may be made for a screening fecal-occult blood test performed after at least 11 months have passed following the month in which the last screening fecal-occult blood test was performed.

(d) *Condition for coverage of screening flexible sigmoidoscopies.* Medicare Part B pays for a screening flexible sigmoidoscopy service if it is performed by a doctor of medicine or osteopathy (as defined in section 1861(r)(1) of the Act).

(e) *Limitations on coverage of screening flexible sigmoidoscopies.* (1) Payment may not be made for a screening flexible sigmoidoscopy performed for an individual under age 50.

(2) For an individual 50 years of age or over, payment may be made for a screening flexible sigmoidoscopy after at least 47 months have passed following the month in which the last screening flexible sigmoidoscopy or, as provided in paragraphs (h) and (i) of this section, the last screening barium enema was performed.

(f) *Condition for coverage of screening colonoscopies.* Medicare Part B pays for a screening colonoscopy if it is performed by a doctor of medicine or osteopathy (as defined in section 1861(r)(1) of the Act).

(g) *Limitations on coverage of screening colonoscopies.* (1) Payment may not be made for a screening colonoscopy for an individual who is not at high risk for colorectal cancer as described in paragraph (a)(3) of this section.

(2) Payment may be made for a screening colonoscopy performed for an individual who is at high risk for colorectal cancer as described in paragraph (a)(3) of this section, after at

least 23 months have passed following the month in which the last screening colonoscopy was performed, or as provided in paragraphs (h) and (i) of this section, the last screening barium enema was performed.

(h) *Conditions for coverage of screening barium enemas.* Medicare Part B pays for a screening barium enema if it is ordered in writing by the beneficiary's attending physician.

(i) *Limitations on coverage of screening barium enemas.* (1) In the case of an individual age 50 or over who is not at high risk of colorectal cancer, payment may be made for a screening barium enema examination performed after at least 47 months have passed following the month in which the last screening barium enema or screening flexible sigmoidoscopy was performed.

(2) In the case of an individual who is at high risk for colorectal cancer, payment may be made for a screening barium enema examination performed after at least 23 months have passed following the month in which the last screening barium enema or the last screening colonoscopy was performed.

[62 FR 59100, Oct. 31, 1997]

§ 410.38 Durable medical equipment: Scope and conditions.

(a) Medicare Part B pays for the rental or purchase of durable medical equipment, including iron lungs, oxygen tents, hospital beds, and wheelchairs, if the equipment is used in the patient's home or in an institution that is used as a home.

(b) An institution that is used as a home may not be a hospital or a CAH or a SNF as defined in sections 1861(e)(1), 1861(mm)(1) and 1819(a)(1) of the Act, respectively.

(c) Wheelchairs may include a power-operated vehicle that may be appropriately used as a wheelchair, but only if the vehicle—

(1) Is determined to be necessary on the basis of the individual's medical and physical condition;

(2) Meets any safety requirements specified by HCFA; and

(3) Except as provided in paragraph (c)(2) of this section, is ordered in writing by a specialist in physical medicine, orthopedic surgery, neurology, or

rheumatology, the written order is furnished to the supplier before the delivery of the vehicle to the beneficiary, and the beneficiary requires the vehicle and is capable of using it.

(4) A written prescription from the beneficiary's physician is acceptable for ordering a power-operated vehicle if a specialist in physical medicine, orthopedic surgery, neurology, or rheumatology is not reasonably accessible. For example, if travel to the specialist would be more than one day's trip from the beneficiary's home or if the beneficiary's medical condition precluded travel to the nearest available specialist, these circumstances would satisfy the "not reasonably accessible" requirement.

(d) Medicare Part B pays for medically necessary equipment that is used for treatment of decubitus ulcers if—

(1) The equipment is ordered in writing by the beneficiary's attending physician, or by a specialty physician on referral from the beneficiary's attending physician, and the written order is furnished to the supplier before the delivery of the equipment; and

(2) The prescribing physician has specified in the prescription that he or she will be supervising the use of the equipment in connection with the course of treatment.

(e) Medicare Part B pays for a medically necessary seat-lift if it—

(1) Is ordered in writing by the beneficiary's attending physician, or by a specialty physician on referral from the beneficiary's attending physician, and the written order is furnished to the supplier before the delivery of the seat-lift;

(2) Is for a beneficiary who has a diagnosis designated by HCFA as requiring a seat-lift; and

(3) Meets safety requirements specified by HCFA.

(f) Medicare Part B pays for transcutaneous electrical nerve stimulator units that are—

(1) Determined to be medically necessary; and

(2) Ordered in writing by the beneficiary's attending physician, or by a specialty physician on referral from the beneficiary's attending physician, and the written order is furnished to

the supplier before the delivery of the unit to the beneficiary.

(g) As a requirement for payment, HCFA may determine through carrier instructions, or carriers may determine that an item of durable medical equipment requires a written physician order before delivery of the item.

[51 FR 41339, Nov. 14, 1986, as amended at 57 FR 57688, Dec. 7, 1992; 58 FR 30668, May 26, 1993]

§ 410.40 Ambulance services: Limitations.

(a) *Definitions.* As used in this section—

Ambulance means a vehicle that—

(1) Is specially designed for transporting the sick or injured;

(2) Contains a stretcher, linens, first aid supplies, oxygen equipment, and other lifesaving equipment required by State or local laws; and

(3) Is staffed with personnel trained to provide first aid treatment.

Appropriate hospital, CAH or SNF refers to a hospital, CAH or SNF that is capable of providing the required level and type of care for the patient's illness or injury and, in the case of a hospital, has available the type of physician or physician specialist needed to treat the patient's condition.

Hospital inpatient or CAH inpatient means a beneficiary who has been formally admitted to a hospital or CAH and has not been formally discharged.

Locality means the service area, surrounding a hospital or CAH or SNF, from which individuals normally come or are expected to come for hospital or CAH or SNF services.

Outside supplier means a hospital or CAH or a nonhospital treatment facility, such as a clinic, therapy center, or physician's office, where a hospital or SNF inpatient may be taken to receive medically necessary diagnostic or therapeutic services not available at the hospital or SNF where he or she is an inpatient.

(b) *Limits on coverage of ambulance transportation.* Medicare Part B pays for ambulance transportation only if—

(1) Other means of transportation would endanger the beneficiary's health;

(2) Medicare Part A payment is not available for the service;